		FOR OHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

I. IDPH Facility ID Number: 0042028

Facility Name: ALDEN NORTH SHORE REHAB & HCC

Address: 5050 WEST TOUHY AVENUE (Number) SKOKIE (City) 60077 (Zip Code)

County: COOK

Telephone Number: (847) 679-6100 **Fax #** (847) 679-3822

IDPA ID Number: 36-3978207

Date of Initial License for Current Owners: 08/06/99

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: STEVEN M. KROLL **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Joan Carl

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds NO CHANGE

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	34,038	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	34,038	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	1,721	17,299	19,020	8
9	SNF/PED					9
10	ICF	1,572	5,386	0	6,958	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,572	7,107	17,299	25,978	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.32%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/14/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/14/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 93 and days of care provided 16,949

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	441,028	31,194		472,222	621	472,843		472,843			1
2	Food Purchase		224,235		224,235	(21,404)	202,831	2,443	205,274			2
3	Housekeeping	82,683	19,161		101,844	716	102,560		102,560			3
4	Laundry	36,606	22,191		58,797	358	59,155		59,155			4
5	Heat and Other Utilities			156,460	156,460		156,460	(2,435)	154,025			5
6	Maintenance	42,678		97,565	140,243	236	140,479	2,583	143,062			6
7	Other (specify):* Related party salary							19,212	19,212			7
8	TOTAL General Services	602,995	296,781	254,025	1,153,801	(19,473)	1,134,328	21,803	1,156,131			8
	B. Health Care and Programs											
9	Medical Director			71,019	71,019		71,019		71,019			9
10	Nursing and Medical Records	1,624,026	131,774	20,477	1,776,277	3,370	1,779,647	(99,738)	1,679,909			10
10a	Therapy	91,300			91,300		91,300		91,300			10a
11	Activities	70,422	1,837	6,203	78,462		78,462		78,462			11
12	Social Services	46,792			46,792		46,792		46,792			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* related party salary							14,366	14,366			15
16	TOTAL Health Care and Programs	1,832,540	133,611	97,699	2,063,850	3,370	2,067,220	(85,372)	1,981,848			16
	C. General Administration											
17	Administrative	17,522			17,522		17,522		17,522			17
18	Directors Fees											18
19	Professional Services			924,997	924,997		924,997	(678,926)	246,071			19
20	Dues, Fees, Subscriptions & Promotions			67,198	67,198		67,198	(61,574)	5,624			20
21	Clerical & General Office Expenses	300,235	27,025	68,587	395,847	235	396,082	45,713	441,795			21
22	Employee Benefits & Payroll Taxes			385,481	385,481	15,868	401,349	(310)	401,039			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,495	1,495		1,495	6,203	7,698			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			81,191	81,191		81,191	10,015	91,206			26
27	Other (specify):* related party salary			28,734	28,734		28,734	253,121	281,855			27
28	TOTAL General Administration	317,757	27,025	1,557,683	1,902,465	16,103	1,918,568	(425,758)	1,492,810			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,753,292	457,417	1,909,407	5,120,116		5,120,116	(489,327)	4,630,789			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC #0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			60,037	60,037		60,037	208,964	269,001			30
31	Amortization of Pre-Op. & Org.			(2,259)	(2,259)		(2,259)	5,792	3,533			31
32	Interest			259,084	259,084		259,084	534,521	793,605			32
33	Real Estate Taxes							228,987	228,987			33
34	Rent-Facility & Grounds			1,042,596	1,042,596		1,042,596	(1,042,596)				34
35	Rent-Equipment & Vehicles			9,238	9,238		9,238	10,413	19,651			35
36	Other (specify):* **Mort Insur Prem**							62,035	62,035			36
37	**TOTAL Ownership**			1,368,696	1,368,696		1,368,696	8,116	1,376,812			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		883,655	1,247,438	2,131,093		2,131,093	97,168	2,228,261			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,059	51,059		51,059		51,059			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		883,655	1,298,497	2,182,152		2,182,152	97,168	2,279,320			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,753,292	1,341,072	4,576,600	8,670,964		8,670,964	(384,043)	8,286,921			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(58,376)	30		9
10	Interest and Other Investment Income	(398)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,998)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(223)	21		17
18	Fines and Penalties	(130)	32		18
19	Entertainment	(4,859)	20		19
20	Contributions	(874)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,801)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,734)	27		24
25	Fund Raising, Advertising and Promotional	(54,283)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(212)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (160,888)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(96,782)	various	34
35	Other- Attach Schedule	(126,373)	PG 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (223,155)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (384,043)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ALDEN NORTH SHORE REHAB & HCC

ID# 0042028

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Valet cost (GL 6907)	$ (33,876)	21	1
2	Late fees on utilities	(3,859)	5	2
3	Intercompany interest (GL7031)	(83,486)	32	3
4	Intercompany interest (GL7053)	(433)	32	4
5	Misc Income (GL4977)	(599)	32	5
6	Marketing Manager (GL6701-100-009)	(2,214)	21	6
7	Back out % of Employee benefits for Mktg Mgr	(310)	22	7
8	Back out 31.78% of PAC fees from standard IHCA bills	(1,596)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(126,373)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,998)	0	0	4,441	0	0	0	0	0	0	0	2,443	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,859)	0	1,424	0	0	0	0	0	0	0	0	(2,435)	5
6	Maintenance	0	0	4,252	0	0	0	(19)	(1,650)	0	0	0	2,583	6
7	Other (specify):*	0	0	19,212	0	0	0	0	0	0	0	0	19,212	7
8	**TOTAL General Services**	(5,857)	0	24,888	4,441	0	0	(19)	(1,650)	0	0	0	21,803	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(78,967)	(20,771)	0	0	0	0	0	0	(99,738)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	14,366	0	0	0	0	0	0	0	0	14,366	15
16	**TOTAL Health Care and Programs**	0	0	14,366	(78,967)	(20,771)	0	0	0	0	0	0	(85,372)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,801)	4,791	(672,916)	0	0	0	0	0	0	0	0	(678,926)	19
20	Fees, Subscriptions & Promotions	(61,824)	0	250	0	0	0	0	0	0	0	0	(61,574)	20
21	Clerical & General Office Expenses	(36,313)	0	16,120	48,712	17,194	0	0	0	0	0	0	45,713	21
22	Employee Benefits & Payroll Taxes	(310)	0	0	0	0	0	0	0	0	0	0	(310)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,203	0	0	0	0	0	0	0	0	6,203	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	9,878	137	0	0	0	0	0	0	0	0	10,015	26
27	Other (specify):*	(28,734)	0	243,781	11,426	26,648	0	0	0	0	0	0	253,121	27
28	**TOTAL General Administration**	(137,982)	14,669	(406,425)	60,138	43,842	0	0	0	0	0	0	(425,758)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(143,839)	14,669	(367,171)	(14,388)	23,071	0	(19)	(1,650)	0	0	0	(489,327)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(58,376)	256,798	9,144	0	1,398	0	0	0	0	0	0	208,964	30
31	Amortization of Pre-Op. & Org.	0	4,969	823	0	0	0	0	0	0	0	0	5,792	31
32	Interest	(85,046)	590,609	23,333	0	1,233	4,392	0	0	0	0	0	534,521	32
33	Real Estate Taxes	0	224,404	3,411	0	1,172	0	0	0	0	0	0	228,987	33
34	Rent-Facility & Grounds	0	(1,042,596)	0	0	0	0	0	0	0	0	0	(1,042,596)	34
35	Rent-Equipment & Vehicles	0	0	10,413	0	0	0	0	0	0	0	0	10,413	35
36	Other (specify):*	0	62,035	0	0	0	0	0	0	0	0	0	62,035	36
37	TOTAL Ownership	(143,422)	96,219	47,124	0	3,803	4,392	0	0	0	0	0	8,116	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(65,777)	(89,956)	252,901	0	0	0	0	0	97,168	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(65,777)	(89,956)	252,901	0	0	0	0	0	97,168	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(287,261)	110,888	(320,047)	(80,165)	(63,082)	257,293	(19)	(1,650)	0	0	0	(384,043)	45

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PG. 7		SEE PG. 6K		SEE PG. 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT INCOME	$ 1,042,596	NORTHSHORE ASSOCIATES, LLC		$	$ (1,042,596)	1
2	V	32	INTEREST INCOME-RR	1,094	NORTHSHORE ASSOCIATES, LLC			(1,094)	2
3	V	32	INT. INCOME-LOAN RECVB'L	174,637	NORTHSHORE ASSOCIATES, LLC			(174,637)	3
4	V	19	AUDIT FEES		NORTHSHORE ASSOCIATES, LLC		3,950	3,950	4
5	V	19	OTHER ADMIN EXPENSES		NORTHSHORE ASSOCIATES, LLC		841	841	5
6	V	33	REAL ESTATE TAXES		NORTHSHORE ASSOCIATES, LLC		224,404	224,404	6
7	V	26	PROPERTY & LIAB INSURANCE		NORTHSHORE ASSOCIATES, LLC		9,878	9,878	7
8	V	32	INT. ON MORTGAGE PAYABLE		NORTHSHORE ASSOCIATES, LLC		589,349	589,349	8
9	V	32	INT. ON OPER. LOSS LOAN		NORTHSHORE ASSOCIATES, LLC		176,991	176,991	9
10	V	36	MORTGAGE INSUR. PREMIUM		NORTHSHORE ASSOCIATES, LLC		62,035	62,035	10
11	V	30	DEPRECIATION		NORTHSHORE ASSOCIATES, LLC		256,798	256,798	11
12	V	31	AMORTIZATION		NORTHSHORE ASSOCIATES, LLC		4,969	4,969	12
13	V	31			NORTHSHORE ASSOCIATES, LLC				13
14	Total			$ 1,218,327			$ 1,329,215	$ * 110,888	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$ 677,955	Alden Management Services	0.00%	$ 5,039	$ (672,916)	15
16	V	21	Clerical and G & A		Alden Management Services		16,120	16,120	16
17	V	5	Utilities		Alden Management Services		1,424	1,424	17
18	V	6	Maintenance		Alden Management Services		4,252	4,252	18
19	V	24	Travel & seminar		Alden Management Services		6,203	6,203	19
20	V	26	Insurance		Alden Management Services		137	137	20
21	V	20	Dues/subscriptions/fees etc		Alden Management Services		250	250	21
22	V	30	Depreciation		Alden Management Services		9,144	9,144	22
23	V	31	Amortization		Alden Management Services		823	823	23
24	V	33	Real estate taxes		Alden Management Services		3,411	3,411	24
25	V	35	Rent-equipment/vehicles		Alden Management Services		10,413	10,413	25
26	V	32	Interest		Alden Management Services		23,333	23,333	26
27	V	7	Salaries-general serv		Alden Management Services		19,212	19,212	27
28	V	15	Salaries-health care		Alden Management Services		14,366	14,366	28
29	V	27	Salaries-general admin		Alden Management Services		243,781	243,781	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 677,955			$ 357,908	$ * (320,047)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube-feeding	$ 19	Pyramid Health Care	100.00%	$ 4,460	$ 4,441	15
16	V	10	nursing supplies	80,987	Pyramid Health Care		2,020	(78,967)	16
17	V	39	perdiem/other supplies	149,494	Pyramid Health Care		83,717	(65,777)	17
18	V	21	gen't & admin		Pyramid Health Care		48,712	48,712	18
19	V	27	gen't & admin		Pyramid Health Care		11,426	11,426	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 230,500			$ 150,335	$ * (80,165)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 383,401	Forum Extended Carew II		$ 330,698	$ (52,703)	15
16	V	10	house stock	2,139	Forum Extended Carew II		1,845	(294)	16
17	V	39	I.V.	271,007	Forum Extended Carew II		233,754	(37,253)	17
18	V				Forum Extended Carew II				18
19	V	21	gen'l & admin		Forum Extended Carew II		17,194	17,194	19
20	V	32	interest		Forum Extended Carew II		1,233	1,233	20
21	V	33	real estate tax		Forum Extended Carew II		1,172	1,172	21
22	V	30	depreciation		Forum Extended Carew II		1,398	1,398	22
23	V	27	General & admin salary		Forum Extended Carew II		26,648	26,648	23
24	V	10	Pharmacy consulting	20,477	Forum Extended Carew II			(20,477)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 677,024			$ 613,942	$ * (63,082)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	therapy	$ 1,191,177	Community Physical Therapy	100.00%	$ 1,444,078	$ 252,901	15
16	V	32	interest		Community Physical Therapy		4,392	4,392	16
17	V	31	amortization		Community Physical Therapy				17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,191,177			$ 1,448,470	$ * 257,293	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	repairs and maintenace	$ 13,078	Alden Bennett Construction		$ 13,059	$ (19)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 13,078			$ 13,059	$ * (19)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Carpet cleaning	$ 12,062	Alden Realty-Carpet Care		$ 10,794	$ (1,268)	15
16	V	6	Floor cleaning	3,920	Alden Realty-Floor Care		3,538	(382)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,982			$ 14,332	$ * (1,650)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	27.00	222,577	0.912	2.28	salary	$ 5,187	27-7	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	1.00	71,874	0.912	2.28	salary	1,675	15-7	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	48,861	0.912	2.28	salary	1,139	7-7	3
4	Joan Carl d.	Secretary	Vice-President	7.50	222,577	0.912	2.28	salary	5,187	27-7	4
5	see others attached on page 7A			2.00							5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	$ 13,188		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	Summary…										2
3	Ami Pissetzki	finance relations	invest/bank	1.00	203,617	0.912	2.28	Salary	4,745	27-7	3
4	Bob Molitor	Vp of Operations	operations	0.50	236,095	0.912	2.28	Salary	5,502	27-7	4
5	Mary Chelotti Smith	In-house counsel	legal advis.	0.50	207,634	0.912	2.28	Salary	4,839	27-7	5
6											6
7											7
8									0		8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,086		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ALDEN MANAGEMENT SERVICES, INC.
Street Address: 4200 W. PETERSON AVE.
City / State / Zip Code: CHICAGO, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE PG. 8A (ALSO ON PG. 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Prudential		X	Mortgage	$53,349.00	3/1/98	$ 8,388,000	$ 8,157,572	9/30/39	7.2000	$ 589,349	1
2	Cambridge		X	Oper Loss Loan	$16,822.00	4/1/03	3,098,700	3,054,155	8/31/39	5.6900	176,991	2
3												3
4												4
5												5
	Working Capital											
6	related party-Ams	X		working capital							23,333	6
7	related party-CPT	X		working capital							4,392	7
8	related party-FECII	X		working capital							1,233	8
9	TOTAL Facility Related				$70,171.00		$ 11,486,700	$ 11,211,727			$ 795,298	9
	B. Non-Facility Related*											
10	offset interest expense with NS Assoc's interest income										(1,094)	10
11	offset interest expense with Corp's interest income										(599)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,693)	14
15	TOTALS (line 9+line14)						$ 11,486,700	$ 11,211,727			$ 793,605	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 62,035 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 196,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 207,104	2
3. Under or (over) accrual (line 2 minus line 1).		$ 11,104	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 213,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 224,404	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	67,899	8
	2000	130,432	9
	2001	129,328	10
	2002	190,237	11
	2003	207,104	12

2004 accrual is based on 103% of 2003 paid tax invoices.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDEN NORTH SHORE REHAB & HCC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042028

CONTACT PERSON REGARDING THIS REPORT STEVEN M. KROLL

TELEPHONE (773) 286-3883 FAX #: (773) 286.3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-28-429-015-0000	Nursing home facility	$ 2,708.35	$ 2,708.35
2.	10-28-429-016-0000	Nursing home facility	$ 1,932.96	$ 1,932.96
3.	10-28-429-017-0000	Nursing home facility	$ 5,548.25	$ 5,548.25
4.	10-28-429-018-0000	Nursing home facility	$ 20,188.06	$ 20,188.06
5.	10-28-429-019-0000	Nursing home facility	$ 20,198.23	$ 20,198.23
6.	10-28-429-020-0000	Nursing home facility	$ 20,053.40	$ 20,053.40
7.	10-28-429-021-0000	Nursing home facility	$ 20,053.40	$ 20,053.40
8.	10-28-429-022-0000	Nursing home facility	$ 20,035.68	$ 20,035.68
9.	10-28-429-023-0000	Nursing home facility	$ 20,017.48	$ 20,017.48
10.	10-28-429-024-0000	Nursing home facility	$ 20,002.19	$ 20,002.19
		TOTALS	$ 150,738.00	$ 150,738.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden North Shore Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 004-2028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-28-429-025-0000	Nursing home facility	$ 20,002.19	$ 20,002.19
2.	10-28-429-026-0000	Nursing home facility	$ 20,002.19	$ 20,002.19
3.	10-28-429-027-0000	Nursing home facility	$ 16,361.23	$ 16,361.23
4.	Support attached (11 pages)	Related Party - Alden Management	$ 149,765.00	$ 3,411.00
5.	Support attached (11 pages)	Related Party - Forum	$ 13,827.00	$ 1,172.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 219,957.61	$ 60,948.61

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,208 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF	34,483	1997	$ 955,797	1
2					2
3	TOTALS	34,483		$ 955,797	3

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 16,213	$	22	$	$	$ 16,213	4
5											5
6	93		1999	1999	6,782,967	195,977	40	169,574	(26,403)	847,870	6
7											7
8											8
	Improvement Type**										
9	draper corp-electric screen			1999	1,252	125	10	125		668	9
10	dakota wiring & comm.-wiring for cable tv			1999	2,500	250	10	250		1,312	10
11	climate serv-repair compressor			1999	1,990	133	15	133		674	11
12	tci cable-install cable			1999	1,254	125	10	125		648	12
13	ABC-install tiles/repair			2000	4,011	267	15	267		1,292	13
14	ABC-mainten-various/construction			2000	5,000	500	10	500		2,417	14
15	ABC-mainten-various/construction			2000	10,000	1,000	10	1,000		4,750	15
16	ABC-mainten-various/construction			2000	10,000	1,000	10	1,000		4,666	16
17	new horizons-phone system			2000	5,744	574	10	574		2,728	17
18	new horizons-phone system & cable			2000	2,784	278	10	278		1,299	18
19	new horizons-phone system			2000	3,742	374	10	374		1,746	19
20	dbs contract.-lawn sprinkler system			2000	1,611	107	15	107		483	20
21	ABC-misc construction work			2000	5,347	1,069	5	1,069		4,456	21
22	ABC-misc construction work			2000	13,118	2,624	5	2,624		10,713	22
23	ABC-misc construction work (12/31/01 finished-begin exp '02)			2001	3,361	336	10	336		1,008	23
24	Laport (walk off mat carpet/floor covering)			2001	3,548	710	5	710		2,247	24
25	The Floor Source (PT carpet/floor covering)			2001	1,576	315	5	315		972	25
26	ABC-beds/bedside cabinets/washers/dryers/bookcases/wallcover			2001	289,721	19,315	15	19,315		77,259	26
27	New Horizon (phone system)			2001	1,256	126	10	126		398	27
28	ABC-misc construction work			2002	19,580	1,305	15	1,305		3,916	28
29	ABC-misc construction work			2002	6,706	447	15	447		1,341	29
30	ABC-misc construction work			2002	16,368	1,091	15	1,091		3,274	30
31	ABC-misc construction work			2003	2,116	212	10	212		423	31
32	GT Mechanical-repair exhaust fans			2003	6,080	608	10	608		1,013	32
33	EWS-repair opxyen alarm ssytem			2003	2,054	411	5	411		616	33
34	ABC-parking lot upgrades			2003	7,538	753	10	753		1,131	34
35	ABC-parking lot repairs			2003	2,943	589	5	589		883	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	GT Mechanical-thermostat equip	2004	1,693	169	10	169		169	38
39	ABC-repair sewer	2004	19,580	1,469	10	1,469		1,469	39
40	GT Mechanical-misc repairs	2004	1,442	192	5	192		192	40
41	GT Mechanical-replace pump	2004	2,496	291	5	291		291	41
42	GT Mechanical-misc repairs	2004	614	72	5	72		72	42
43	ABC-bath,plumb. Upgrade	2004	1,813	106	10	106		106	43
44	ABC-painting supplies	2004	1,258	126	5	126		126	44
45	GT Mechanical-Electric improvement	2004	917	31	10	31		31	45
46	ABC-plumbing/misc. repairs	2004	3,971	99	10	99		99	46
47	CAPPS Plumb.-ceiling repair	2004	1,480	12	10	12		12	47
48	TopNotch-motor drive repair	2004	3,139	26	10	26		26	48
49	ABD- carpet repairs	2004	4,943	41	10	41		41	49
50	ABC-misc repairs	2004	2,783	298	7	298		298	50
51	ABC parking lot improve.	2004	16,008	400	10	400		400	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,292,516	$ 233,953		$ 207,550	$ (26,403)	$ 999,748	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,292,516	$ 233,953		$ 207,550	$ (26,403)	$ 999,748	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	12,303		15			12,303	4
5	Leasehold Improvement-Remodeling	1980	19,273		20			19,273	5
6	Leasehold Improvement-Tenant Improvement	1987	996		13			996	6
7	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	7
8	Leasehold Improvement-Roof	1994	3,572	223	16	223		2,234	8
9	Leasehold Improvement-Build.Improv.	1996	1,259	79	16	79		704	9
10	Leasehold Improvement-Asphalting	2000	98		3			98	10
11	Leasehold Improvement-DAI	2001	172	17	10	17		54	11
12	Leasehold Improvement-Bathrooms	2002	733	82	7	82		181	12
13	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		328	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,820	148	7	148		148	14
15	Leasehold Improvement-Add-on Improvement, fixture base	1980	79		23			79	15
16	Leasehold Improvement-Add-on Improvement, lighting base	2001	137	27	5	27		103	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	27
28	Leasehold Improvement-Remodeling	2002	4,861	608	7	608		1,215	28
29	Leasehold Improvement-Remodeling	2003	5,085	775	7	775		1,394	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	13,393	266	30	266		2,041	33
34	TOTAL (lines 1 thru 33)		$ 7,378,212	$ 236,342		$ 209,939	$ (26,403)	$ 1,061,177	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 551,551	$ 77,732	$ 45,760	$ (31,972)	various	$ 312,374	71
72	Current Year Purchases	21,214	1,729	1,729		various	1,729	72
73	Fully Depreciated Assets	47,882	1,478	1,478		various	47,882	73
74								74
75	TOTALS	$ 620,647	$ 80,939	$ 48,967	$ (31,972)		$ 361,985	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car/engine/bus/van	variosu/van	98-'04	$ 8,164	$ 130	$ 130	$	3	$ 7,981	76
77	Bys-van	01 Bus	01	49,826	9,965	9,965		5	39,861	77
78										78
79										79
80	TOTALS			$ 57,990	$ 10,095	$ 10,095	$		$ 47,842	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,012,646	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 327,376	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 269,001	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (58,375)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,471,004	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related party-cost is backed out.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 3/01/00
Ending 12/31/2039

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$ 791,604
13.	/2006	$ 791,604
14.	/2007	$ 791,604

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 9,238 Description: copy machine lease,$8,250-postage meter<$988.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Related party		$ 868.00	$ 10,413	17
18					18
19					19
20					20
21	TOTAL		$ 868.00	$ 10,413	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Skilled nrses on site

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 430,039	$		$ 430,039	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			62,167			62,167	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			698,974			698,974	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescrpts				293,445		293,445	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See Pg 16A				252,901	490,735		743,636	13
14	TOTAL			$		$ 1,444,081	$ 784,180		$ 2,228,261	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

ALDEN NORTHSHORE REHAB & HCC

2004

		Page 16 Col 5: PT,OT, & ST Col 6: Other Amount
XIV. SPECIAL SERVICES (Direct Cost)		
Service		
1. OT	39-3	$430,039.00
2. ST	39-3	62,167.00
3.		
4. PT	39-3	698,974.00
5.		
6.		
7.		
8.		
9. Phamacy	See pg 16A	383,401.00
Plus: Related Party- Forum Drugs		(52,703.00)
Plus: Related Party- Forum I.V.		(37,253.00)
Total to line 9 Pharmacy		293,445.00
10.		
11.		
12. Exceptional Care-Column 3	See pg 16A	0.00
12. Exceptional Care-Column 6	See pg 16A	0.00
13.Other : Lab,x-ray therapy,Mattress,Pyramid billings		553,772.00
Related Party- Pyramid		(65,777.00)
Related Party- CPT		252,901.00
Oxygen Costs-IDPA		2,740.00
Total to line 13		743,636.00
14. Total		2,228,261.00

STATE OF ILLINOIS

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 121	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 135,000)	1,122,006	1,122,006	3
4	Supply Inventory (priced at)	537	537	4
5	Short-Term Investments			5
6	Prepaid Insurance	1,765	49,981	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	27,933	27,933	8
9	Other(specify): Due from 3rd parties	8,888	8,888	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,161,129	$ 1,209,466	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		955,797	13
14	Buildings, at Historical Cost		7,839,086	14
15	Leasehold Improvements, at Historical Cost	497,803	497,803	15
16	Equipment, at Historical Cost	159,282	1,071,589	16
17	Accumulated Depreciation (book methods)	(221,814)	(1,590,535)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		98,700	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(4,969)	20
21	Restricted Funds		472,147	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 435,271	$ 9,339,618	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,596,400	$ 10,549,084	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,070,993	$ 2,070,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,084	46,084	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	221,677	221,677	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,670	11,670	31
32	Accrued Real Estate Taxes(Sch.IX-B)		213,300	32
33	Accrued Interest Payable		63,428	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accrued exp,idpa misc	20,759	20,759	36
37	Due to affiliates	161,219	111,824	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,532,402	$ 2,759,735	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,054,155		39
40	Mortgage Payable		11,211,727	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,054,155	$ 11,211,727	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,586,557	$ 13,971,462	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,990,157)	$ (3,422,378)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,596,400	$ 10,549,084	48

*(See instructions.)

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,410,151)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,410,151)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	419,994	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 419,994	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,990,157)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,961,609	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,961,609	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	82,585	6
7	Oxygen	3,805	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 86,390	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	23	12
13	Barber and Beauty Care	1,598	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,283	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(12,268)	19
20	Radiology and X-Ray	175	20
21	Other Medical Services	39,647	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 34,458	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	398	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 398	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Recoveries,vendor settlements	8,103	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,103	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,090,958	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,153,801	31
32	Health Care	2,063,850	32
33	General Administration	1,902,465	33
	B. Capital Expense		
34	Ownership	1,368,696	34
	C. Ancillary Expense		
35	Special Cost Centers	2,131,093	35
36	Provider Participation Fee	51,059	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,670,964	40
41	**Income before Income Taxes (line 30 minus line 40)****	419,994	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 419,994	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,080	$ 73,401	$ 35.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,074	21,866	616,766	28.21	3
4	Licensed Practical Nurses	8,778	8,892	210,912	23.72	4
5	Nurse Aides & Orderlies	50,253	51,875	627,979	12.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,920	2,000	24,639	12.32	8
9	Activity Director	1,464	1,648	29,109	17.66	9
10	Activity Assistants	6,359	6,524	72,556	11.12	10
11	Social Service Workers	1,992	2,080	46,792	22.50	11
12	Dietician					12
13	Food Service Supervisor	2,218	2,330	55,702	23.91	13
14	Head Cook	5,032	5,120	74,961	14.64	14
15	Cook Helpers/Assistants	29,869	31,933	310,366	9.72	15
16	Dishwashers					16
17	Maintenance Workers	2,056	2,080	44,024	21.17	17
18	Housekeepers	9,720	10,405	82,683	7.95	18
19	Laundry	4,588	4,815	36,606	7.60	19
20	Administrator	440	440	16,176	36.76	20
21	Assistant Administrator	1,568	1,680	64,630	38.47	21
22	Other Administrative	4,831	5,036	150,864	29.96	22
23	Office Manager					23
24	Clerical	4,776	4,904	55,892	11.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,016	2,088	60,807	29.12	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	564	568	5,677	9.99	31
32	Other Health C: Cl Supp Sup	1,936	2,032	63,901	31.45	32
33	Other(specify) Volunteer Coor	1,500	1,560	28,849	18.49	33
34	TOTAL (lines 1 - 33)	164,898	171,956	$ 2,753,292 *	$ 16.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	5918/mo	71,019	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	186/mo	2,232	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	99	2,880	11-3	44
45	Social Service Consultant	8	448	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	107	$ 76,579		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
E. Foutris			$ 17,522
Note: additional adminstratror salaries were allocated to this facility from the home office and are included on line 27.			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 17,522

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management	Management Fees	$ 677,955
BDO	Acctg. Fees	7,127
Ken Fisch	Legal Fees	20,021
Martin Malin	Union Arbitrator	4,125
Neal Gerber & Eisenberg	Legal Fees	79,247
Medicom	Billing consultant	183
AMS	Legal Fees	563
Dart Chart Systems,LLC	Medicare Consultant	135,776
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 924,997

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,876
Unemployment Compensation Insurance	39,532
FICA Taxes	198,590
Employee Health Insurance	72,792
Employee Meals	21,404
Illinois Municipal Retirement Fund (IMRF)*	
Dental,Life	2,043
Emp. Relations,misc	974
Drug test,401K vacciantions	3,138
Marketing dept benefits	(310)
TOTAL (agree to Schedule V, line 22, col.8)	$ 401,039

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	802
Health Care Worker Background Check (Indicate # of checks performed)	199
Il Health Care Assoc	3,426
Surety bond fee& dues	947
Related Party	250
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,624

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
auto/gas	805
Related Party-AMS	6,203
Seminar Expense	
training reimbursement	690
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,698

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	painting>$1500 for 2000	7/00	$ 2,176	3	$ 725	$ 725	$ 363	$ 0	$	$	$	$	$
2	GT Mechanical-repair hot	10/03	2,258	3			188	753	753	564	0	0	
3	ABC-repair water booster	6/03	2,209	3			429	736	736	308	0	0	
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,643		$ 725	$ 725	$ 980	$ 1,489	$ 1,489	$ 872	$	$	$

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Ill Health Care Assoc.-$5022**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,148** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **51,059**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,404** Has any meal income been offset against related costs? **None** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. **Not required**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(21,404)	Employee Meal
	22	21,404	Employee Meal
22		(5,536)	Uniforms
	10	3,370	Uniforms
	6	236	Uniforms
	4	358	Uniforms
	1	621	Uniforms
	3	716	Uniforms
	11	0	Uniforms
	21	235	Uniforms
		0	Net should be 0